



Phone: 1-800-809-1265 Fax: 1-888-417-3658

MRN: \_\_\_\_\_

DOB: \_\_\_\_\_

## Standard Plan of Treatment for Generic Orders

**NOTE:** We *may* require a detailed Letter of Medical Necessity or clinical supporting documentation (depending on diagnosis), to be able to verify eligibility and payment for this treatment through Medicare and/or other insurance plans.

**1. Patient Name:** \_\_\_\_\_ Height (inches): \_\_\_\_\_ Weight (lbs): \_\_\_\_\_

**2. Allergies:** \_\_\_\_\_

**3. Diagnosis:**  Primary ICD-10 Code: \_\_\_\_\_ Diagnosis description: \_\_\_\_\_

Secondary ICD-10 Code: \_\_\_\_\_ Diagnosis description: \_\_\_\_\_

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**4. Pre-medications:** Administered 30 minutes prior to infusion as selected:

Acetaminophen: <input type="checkbox"/> 1000 mg PO <input type="checkbox"/> 650 mg PO <input type="checkbox"/> 500 mg PO <input type="checkbox"/> 325 mg PO	Diphenhydramine: <input type="checkbox"/> 25 mg PO, <input type="checkbox"/> 50 mg PO, <input type="checkbox"/> 25 mg IVP, <input type="checkbox"/> 50 mg IVP or Fexofenadine <input type="checkbox"/> 60mg or <input type="checkbox"/> 180 mg, <input type="checkbox"/> Cetirizine 10 mg, <input type="checkbox"/> Loratadine 10 mg Methylprednisolone <input type="checkbox"/> 40 mg IVP <input type="checkbox"/> 125 mg IVP or other _____ mg IVP Famotidine: <input type="checkbox"/> 20 mg PO, <input type="checkbox"/> 40 mg PO, <input type="checkbox"/> 20 mg IVP, <input type="checkbox"/> 40 mg IVP
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Pre-medicate with other: \_\_\_\_\_

**4. Drug:** \_\_\_\_\_

**5. Dose:** \_\_\_\_\_ to infuse over \_\_\_\_\_ minute(s), \_\_\_\_\_ hour(s)

**6. Administered via (check one):**

Intravenously – Subcutaneously (SQ) – Intramuscular (IM) – IVP

**7. Frequency:** \_\_\_\_\_

Post infusion monitoring as per protocol or as suggested in product information of \_\_\_\_\_ minutes

**Special orders:** \_\_\_\_\_

***If adverse drug reaction occurs, utilize the ADVERSE DRUG REACTION GUIDELINES***

**8. Physician's Signature:** \_\_\_\_\_ / \_\_\_\_\_ Date: \_\_\_\_\_

No Stamp Signatures

(Dispense as written)

(Substitution permitted)

Printed Physician's Name with Credentials: \_\_\_\_\_ NPI: \_\_\_\_\_

**9. Fax updated supporting clinical MD notes with each order renewal or change in orders**

Infusion order forms and Adverse Drug Reaction Guidelines are available at [www.palmettoinfusion.com](http://www.palmettoinfusion.com)



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MRN: \_\_\_\_\_

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### Guidelines for Prescribing (Required documentation with all initial referrals)

Patient Name: \_\_\_\_\_

Referral Date: \_\_\_\_\_

\_\_\_ Include signed and completed **Plan of Treatment**. (MD must complete sections 1-9)  
(Infusion order forms & Standard Adverse Reactions orders are available at [www.palmettoinfusion.com](http://www.palmettoinfusion.com) under Agency/MD tab)

\_\_\_ Include patient demographic information and insurance information. (Copy of insurance cards if available)

\_\_\_ **Supporting clinical MD notes to include any past tried and/or failed therapies, intolerance, outcomes or contraindications to conventional therapy. Include any lab results and/or tests to support diagnosis.**

\_\_\_ Other as requested: \_\_\_\_\_  
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**Palmetto Infusion Services will complete insurance verification and submit all required clinical documentation to the patient’s insurance company for eligibility. Our office will notify you if any further information is required. We will review financial responsibility with the patient and refer them to any available Co-pay assistance as required. Thank you for the referral.**

**Please fax all information to 1-888-417-3658 or call 1-800-809-1265 for assistance.**